

D R A F T

SUMMARY

Digest: The Act repeals laws creating certain health care entities. The Act removes some duties of OHA and transfers some duties from OHPB to OHA. The Act changes the membership of certain boards and committees. The Act makes changes to PEBB and OEGB. (Flesch Readability Score: 75.3).

Repeals the Palliative Care and Quality of Life Interdisciplinary Advisory Council.

Removes the requirement that the Oregon Health Authority hold annual public hearings as part of the Health Care Cost Growth Target program.

Removes the requirement that the authority conduct a quadrennial study on health care consolidation.

Repeals the Health Plan Quality Metrics Committee and transfers duties.

Transfers duties from the Oregon Health Policy Board to the authority to allocate the moneys in the Health Care Provider Incentive Fund. Requires the authority to submit a biennial report to the board regarding the allocation of moneys in the fund.

Modifies the membership of the Health Insurance Exchange Advisory Committee.

Modifies the membership of the Oregon Educators Benefit Board.

Allows the Oregon Educators Benefit Board and the Public Employees' Benefit Board, in soliciting contracts for employee benefit plans, to withhold from disclosure the contents of a proposal before a notice of intent to award a contract is issued.

Makes members of a collective bargaining unit that represents police officers and fire-fighters eligible employees for purposes of benefit plans offered by the Public Employees' Benefit Board.

A BILL FOR AN ACT

Relating to health care; creating new provisions; amending ORS 243.105, 243.135, 243.862, 243.866, 279A.025, 413.017, 413.022, 413.032, 413.273, 414.025, 417.721, 442.386, 676.467 and 741.004 and section 2, chapter 575, Oregon Laws 2015, and section 15, chapter 584, Oregon Laws 2023; and repealing ORS 413.270, 413.271 and 415.510 and section 6a, chapter 615, Oregon Laws 2021.

Be It Enacted by the People of the State of Oregon:

**REPEAL OF PALLIATIVE CARE AND QUALITY OF LIFE INTERDISCIPLINARY
ADVISORY COUNCIL**

SECTION 1. ORS 413.270 and 413.271 are repealed.

SECTION 2. ORS 413.273 is amended to read:

413.273. (1) As used in this section [*and ORS 413.270 and 413.271*]:

(a) “Appropriate” means consistent with applicable legal, health and professional standards, a patient’s clinical and other circumstances, and the patient’s known wishes and beliefs.

(b) “Health facility” includes:

(A) Hospitals and long term care facilities licensed under ORS 441.025; and

(B) Residential facilities licensed under ORS 443.415.

(c) “Medical care” means professional services for a patient that are provided, requested or supervised by a physician, nurse practitioner or physician associate.

(d)(A) “Palliative care” means patient-centered and family-centered medical care that optimizes a patient’s quality of life by anticipating, preventing and treating the suffering caused by serious illness and involves addressing the patient’s physical, social and spiritual needs and facilitating the patient’s autonomy, access to information and choice.

(B) “Palliative care” includes, but is not limited to:

(i) Discussing a patient’s goals for treatment;

(ii) Discussing the treatment options that are appropriate for the patient; and

(iii) Comprehensive pain and symptom management.

(e) “Serious illness” means any illness, physical injury or condition that substantially impairs a patient’s quality of life for more than a short period of time.

(2) A health facility shall:

(a) Establish a system for identifying patients or residents who could benefit from palliative care;

(b) Provide information to patients, residents and their families about palliative care; and

(c) Coordinate with a patient’s or resident’s primary care provider, if practicable, to facil-

1 itate the access of patients and residents with serious illnesses to appropriate palliative care.

3 **HEALTH CARE COST GROWTH TARGET PROGRAM**

5 **SECTION 3.** ORS 442.386 is amended to read:

6 442.386. (1) The Legislative Assembly intends to establish a health care cost growth tar-
7 get, for all providers and payers, to:

8 (a) Support accountability for the total cost of health care across all providers and payers,
9 both public and private;

10 (b) Build on the state's existing efforts around health care payment reform and contain-
11 ment of health care costs; and

12 (c) Ensure the long-term affordability and financial sustainability of the health care sys-
13 tem in this state.

14 (2) The Health Care Cost Growth Target program is established. The program shall be
15 administered by the Oregon Health Authority in collaboration with the Department of Con-
16 sumer and Business Services, subject to the oversight of the Oregon Health Policy Board. The
17 program shall establish a health care cost growth target for increases in total health expendi-
18 tures and shall review and modify the target on a periodic basis.

19 (3) The health care cost growth target must:

20 (a) Promote a predictable and sustainable rate of growth for total health expenditures as
21 measured by an economic indicator adopted by the board, such as the rate of increase in this
22 state's economy or of the personal income of residents of this state;

23 (b) Apply to all providers and payers in the health care system in this state;

24 (c) Use established economic indicators; and

25 (d) Be measurable on a per capita basis, statewide basis and health care entity basis.

26 (4) The program shall establish a methodology for calculating health care cost growth:

27 (a) Statewide;

28 (b) For each provider and payer, taking into account the health status of the patients of
29 the provider or the beneficiary of the payer; and

30 (c) Per capita.

31 (5)(a) The program shall establish requirements for providers and payers to report data

1 and other information necessary to calculate health care cost growth under subsection (4) of
2 this section.

3 (b) Based on a methodology determined by the authority, each provider shall report an-
4 nually the provider's aggregate amount of total compensation.

5 (6) Annually, the program shall:

6 [*(a) Hold public hearings on the growth in total health expenditures in relation to the*
7 *health care cost growth in the previous calendar year;*]

8 [(b)] (a) Publish a report on health care costs and spending trends that includes:

9 (A) Factors impacting costs and spending; and

10 (B) Recommendations for strategies to improve the efficiency of the health care system;
11 and

12 [(c)] (b) For providers and payers for which health care cost growth in the previous cal-
13 endar year exceeded the health care cost growth target:

14 (A) Analyze the cause for exceeding the health care cost growth target; and

15 (B) Require the provider or payer to develop and undertake a performance improvement
16 plan.

17 (7)(a) The authority shall adopt by rule criteria for waiving the requirement for a
18 provider or payer to undertake a performance improvement plan, if necessitated by unfore-
19 seen market conditions or other equitable factors.

20 (b) The authority shall collaborate with a provider or payer that is required to develop
21 and undertake a performance improvement plan by:

22 (A) Providing a template for performance improvement plans, guidelines and a time
23 frame for submission of the plan;

24 (B) Providing technical assistance such as webinars, office hours, consultation with tech-
25 nical assistance providers or staff, or other guidance; and

26 (C) Establishing a contact at the authority who can work with the provider or payer in
27 developing the performance improvement plan.

28 (8) A performance improvement plan must:

29 (a) Identify key cost drivers and include concrete steps a provider or payer will take to
30 address the cost drivers;

31 (b) Identify an appropriate time frame by which a provider or payer will reduce the cost

drivers and be subject to an evaluation by the authority; and

(c) Have clear measurements of success.

(9) The authority shall adopt by rule criteria for imposing a financial penalty on any provider or payer that exceeds the cost growth target without reasonable cause in three out of five calendar years or on any provider or payer that does not participate in the program. The criteria must be based on the degree to which the provider or payer exceeded the target and other factors, including but not limited to:

(a) The size of the provider or payer organization;

(b) The good faith efforts of the provider or payer to address health care costs;

(c) The provider's or payer's cooperation with the authority or the department;

(d) Overlapping penalties that may be imposed for failing to meet the target, such as requirements relating to medical loss ratios; and

(e) A provider's or payer's overall performance in reducing cost across all markets served by the provider or payer.

(10) A provider shall not be accountable for cost growth resulting from the provider's total compensation.

HEALTH CARE MARKET OVERSIGHT PROGRAM

SECTION 4. ORS 415.510 and section 6a, chapter 615, Oregon Laws 2021, are repealed.

REPEAL OF HEALTH PLAN QUALITY METRICS COMMITTEE

SECTION 5. ORS 413.017 is amended to read:

413.017. (1) The Oregon Health Policy Board shall establish the committees described in subsections (2) to [(5)] **(4)** of this section.

(2)(a) The Public Health Benefit Purchasers Committee shall include individuals who purchase health care for the following:

(A) The Public Employees' Benefit Board.

(B) The Oregon Educators Benefit Board.

1 (C) Trustees of the Public Employees Retirement System.

2 (D) A city government.

3 (E) A county government.

4 (F) A special district.

5 (G) Any private nonprofit organization that receives the majority of its funding from the
6 state and requests to participate on the committee.

7 (b) The Public Health Benefit Purchasers Committee shall:

8 (A) Identify and make specific recommendations to achieve uniformity across all public
9 health benefit plan designs based on the best available clinical evidence, recognized best
10 practices for health promotion and disease management, demonstrated cost-effectiveness
11 and shared demographics among the enrollees within the pools covered by the benefit plans.

12 (B) Develop an action plan for ongoing collaboration to implement the benefit design
13 alignment described in subparagraph (A) of this paragraph and shall leverage purchasing to
14 achieve benefit uniformity if practicable.

15 (C) Continuously review and report to the Oregon Health Policy Board on the commit-
16 tee's progress in aligning benefits while minimizing the cost shift to individual purchasers of
17 insurance without shifting costs to the private sector or the health insurance exchange.

18 (c) The Oregon Health Policy Board shall work with the Public Health Benefit Pur-
19 chasers Committee to identify uniform provisions for state and local public contracts for
20 health benefit plans that achieve maximum quality and cost outcomes. The board shall col-
21 laborate with the committee to develop steps to implement joint contract provisions. The
22 committee shall identify a schedule for the implementation of contract changes. The process
23 for implementation of joint contract provisions must include a review process to protect
24 against unintended cost shifts to enrollees or agencies.

25 (3)(a) The Health Care Workforce Committee shall include individuals who have the col-
26 lective expertise, knowledge and experience in a broad range of health professions, health
27 care education and health care workforce development initiatives.

28 (b) The Health Care Workforce Committee shall coordinate efforts to recruit and educate
29 health care professionals and retain a quality workforce to meet the demand that will be cre-
30 ated by the expansion in health care coverage, system transformations and an increasingly
31 diverse population.

(c) The Health Care Workforce Committee shall conduct an inventory of all grants and other state resources available for addressing the need to expand the health care workforce to meet the needs of Oregonians for health care.

[(4)(a) The Health Plan Quality Metrics Committee shall include the following members appointed by the Oregon Health Policy Board:]

[(A) An individual representing the Oregon Health Authority;]

[(B) An individual representing the Oregon Educators Benefit Board;]

[(C) An individual representing the Public Employees' Benefit Board;]

[(D) An individual representing the Department of Consumer and Business Services;]

[(E) Two health care providers;]

[(F) One individual representing hospitals;]

[(G) One individual representing insurers, large employers or multiple employer welfare arrangements;]

[(H) Two individuals representing health care consumers;]

[(I) Two individuals representing coordinated care organizations;]

[(J) One individual with expertise in health care research;]

[(K) One individual with expertise in health care quality measures; and]

[(L) One individual with expertise in mental health and addiction services.]

[(b) The committee shall work collaboratively with the Oregon Educators Benefit Board, the Public Employees' Benefit Board, the authority and the department to adopt health outcome and quality measures that are focused on specific goals and provide value to the state, employers, insurers, health care providers and consumers. The committee shall be the single body to align health outcome and quality measures used in this state with the requirements of health care data reporting to ensure that the measures and requirements are coordinated, evidence-based and focused on a long term statewide vision.]

[(c) The committee shall use a public process that includes an opportunity for public comment to identify health outcome and quality measures. The health outcome and quality measures identified by the committee, as updated by the authority under paragraph (g) of this subsection, may be applied to services provided by coordinated care organizations or paid for by health benefit plans sold through the health insurance exchange or offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board. The authority, the]

1 *department, the Oregon Educators Benefit Board and the Public Employees' Benefit Board*
 2 *are not required to adopt all of the health outcome and quality measures identified by the*
 3 *committee but may not adopt any health outcome and quality measures that are different*
 4 *from the measures identified by the committee. The measures must take into account the*
 5 *health outcome and quality measures selected by the metrics and scoring subcommittee cre-*
 6 *ated in ORS 413.022 and the differences in the populations served by coordinated care orga-*
 7 *nizations and by commercial insurers.]*

8 *[(d) In identifying health outcome and quality measures, the committee shall prioritize*
 9 *measures that:]*

10 *[(A) Utilize existing state and national health outcome and quality measures, including*
 11 *measures adopted by the Centers for Medicare and Medicaid Services, that have been*
 12 *adopted or endorsed by other state or national organizations and have a relevant state or na-*
 13 *tional benchmark;]*

14 *[(B) Given the context in which each measure is applied, are not prone to random varia-*
 15 *tions based on the size of the denominator;]*

16 *[(C) Utilize existing data systems, to the extent practicable, for reporting the measures to*
 17 *minimize redundant reporting and undue burden on the state, health benefit plans and*
 18 *health care providers;]*

19 *[(D) Can be meaningfully adopted for a minimum of three years;]*

20 *[(E) Use a common format in the collection of the data and facilitate the public reporting*
 21 *of the data; and]*

22 *[(F) Can be reported in a timely manner and without significant delay so that the most*
 23 *current and actionable data is available.]*

24 *[(e) The committee shall evaluate on a regular and ongoing basis the health outcome and*
 25 *quality measures identified under this section.]*

26 *[(f) The committee may convene subcommittees to focus on gaining expertise in particu-*
 27 *lar areas such as data collection, health care research and mental health and substance use*
 28 *disorders in order to aid the committee in the development of health outcome and quality*
 29 *measures. A subcommittee may include stakeholders and staff from the authority, the De-*
 30 *partment of Human Services, the Department of Consumer and Business Services, the Early*
 31 *Learning Council or any other agency staff with the appropriate expertise in the issues]*

1 *addressed by the subcommittee.]*

2 *[(g) The authority shall update annually, if necessary, the health outcome and quality*
 3 *measures identified by the committee to utilize the latest sets of core quality measures pub-*
 4 *lished by the Centers for Medicare and Medicaid Services in accordance with 42 U.S.C.*
 5 *1320b-9a and 1320b-9b.]*

6 *[(h) This subsection does not prevent the authority, the Department of Consumer and*
 7 *Business Services, commercial insurers, the Public Employees' Benefit Board or the Oregon*
 8 *Educators Benefit Board from establishing programs that provide financial incentives to*
 9 *providers for meeting specific health outcome and quality measures adopted by the commit-*
 10 *tee.]*

11 *[(5)(a)]* **(4)(a)** The Behavioral Health Committee shall include the following members
 12 appointed by the Director of the Oregon Health Authority:

13 (A) *[The chairperson of the Health Plan Quality Metrics Committee]* **A member of the**
 14 **Metrics and Scoring Committee established in ORS 413.022 or a similar committee,**
 15 **board or advisory group;**

16 (B) The chairperson of the committee appointed by the board to address health equity, if
 17 any;

18 (C) A behavioral health director for a coordinated care organization;

19 (D) A representative of a community mental health program;

20 (E) An individual with expertise in data analysis;

21 (F) A member of the Consumer Advisory Council, established under ORS 430.073, that
 22 represents adults with mental illness;

23 (G) A representative of the System of Care Advisory Council established in ORS 418.978;

24 (H) A member of the Oversight and Accountability Council, established under ORS
 25 430.388, who represents adults with addictions or co-occurring conditions;

26 (I) One member representing a system of care, as defined in ORS 418.976;

27 (J) One consumer representative;

28 (K) One representative of a tribal government;

29 (L) One representative of an organization that advocates on behalf of individuals with
 30 intellectual or developmental disabilities;

31 (M) One representative of providers of behavioral health services;

(N) The director of the division of the authority responsible for behavioral health services, as a nonvoting member;

(O) The Director of the Alcohol and Drug Policy Commission appointed under ORS 430.220, as a nonvoting member;

(P) The authority's Medicaid director, as a nonvoting member;

(Q) A representative of the Department of Human Services, as a nonvoting member; and

(R) Any other member that the director deems appropriate.

(b) The board may modify the membership of the committee as needed.

(c) The division of the authority responsible for behavioral health services and the director of the division shall staff the committee.

(d) The committee, in collaboration with [*the Health Plan Quality Metrics Committee*] **other health care incentive committees, boards or advisory groups**, as needed, shall:

(A) Establish quality metrics for behavioral health services provided by coordinated care organizations, health care providers, counties and other government entities; and

(B) Establish incentives to improve the quality of behavioral health services.

(e) The quality metrics and incentives shall be designed to:

(A) Improve timely access to behavioral health care;

(B) Reduce hospitalizations;

(C) Reduce overdoses;

(D) Improve the integration of physical and behavioral health care; and

(E) Ensure individuals are supported in the least restrictive environment that meets their behavioral health needs.

[(6)] **(5)** Members of the committees described in subsections (2) to [(5)] **(4)** of this section who are not members of the Oregon Health Policy Board may receive compensation in accordance with criteria prescribed by the authority by rule and shall be reimbursed from funds available to the board for actual and necessary travel and other expenses incurred by them by their attendance at committee meetings, in the manner and amount provided in ORS 292.495.

SECTION 6. ORS 413.022 is amended to read:

413.022. (1) As used in this section:

(a) "Downstream health outcome and quality measures" means:

(A) The sets of core quality measures for the Medicaid program that are published by the Centers for Medicare and Medicaid Services in accordance with 42 U.S.C. 1320b-9a and 1320b-9b; and

(B) If the sets of core quality measures for adults published by the Centers for Medicare and Medicaid Services do not include quality measures for oral health care for adults, quality measures of oral health care for adults adopted by the metrics and scoring subcommittee.

(b) “Upstream health outcome and quality measures” means quality measures that focus on the social determinants of health.

(2) There is created in the [*Health Plan Quality Metrics Committee*] **Oregon Health Authority** a nine-member [*metrics and scoring subcommittee*] **Metrics and Scoring Committee** appointed by the Director of the Oregon Health Authority. **The committee shall be under the guidance of the Oregon Health Policy Board.** The members of the [*subcommittee*] **committee** serve two-year terms and must include:

(a) Three members at large;

(b) Three individuals with expertise in health outcomes measures; and

(c) Three representatives of coordinated care organizations.

(3) The [*subcommittee*] **committee** shall use a public process in accordance with ORS 192.610 to 192.705 that includes an opportunity for public comment to select the downstream health outcome and quality measures and a minimum of four upstream health outcome and quality measures applicable to services provided by coordinated care organizations.

(4) The [*Oregon Health Authority*] **authority** shall incorporate these measures into coordinated care organization contracts to hold the organizations accountable for performance and customer satisfaction requirements. The authority shall notify each coordinated care organization of any changes in the measures at least three months before the beginning of the contract period during which the new measures will be in place.

(5) The [*subcommittee*] **committee** shall update the health outcome and quality measures annually, if necessary, to conform to the latest sets of core quality measures published by the Centers for Medicare and Medicaid Services.

(6) All health outcome and quality measures must be consistent with the:

(a) Terms and conditions of the demonstration project approved for this state by the Cen-

ters for Medicare and Medicaid Services under 42 U.S.C. 1315; and

(b) Written quality strategies approved by the Centers for Medicare and Medicaid Services under 42 C.F.R. 438.340 and 457.1240.

(7) The authority and the [*Oregon Health Policy Board*] **board** shall evaluate on a regular and ongoing basis the outcome and quality measures selected by the [*subcommittee*] **committee** under this section for members in each coordinated care organization and for members statewide.

(8) Members of the [*subcommittee*] **committee** who are not members of the [*Oregon Health Policy Board*] **board** may receive compensation and the reimbursement of actual and necessary travel and other expenses incurred by them in the performance of their official duties in accordance with criteria adopted by the authority by rule and shall be reimbursed from funds available to the authority in the manner and amount provided in ORS 292.495.

SECTION 7. ORS 413.032 is amended to read:

413.032. (1) The Oregon Health Authority is established. The authority shall:

(a) Carry out policies adopted by the Oregon Health Policy Board;

(b) Administer the Oregon Integrated and Coordinated Health Care Delivery System established in ORS 414.570 and the COFA Dental Program established in ORS 413.614;

(c) Administer the Oregon Prescription Drug Program;

(d) Develop the policies for and the provision of publicly funded medical care and medical assistance in this state;

(e) Develop the policies for and the provision of mental health treatment and treatment of addictions;

(f) Assess, promote and protect the health of the public as specified by state and federal law;

(g) Provide regular reports to the board with respect to the performance of health services contractors serving recipients of medical assistance, including reports of trends in health services and enrollee satisfaction;

(h) Guide and support, with the authorization of the board, community-centered health initiatives designed to address critical risk factors, especially those that contribute to chronic disease;

(i) Be the state Medicaid agency for the administration of funds from Titles XIX and XXI

1 of the Social Security Act and administer medical assistance under ORS chapter 414;

2 (j) In consultation with the Director of the Department of Consumer and Business Ser-
3 vices, periodically review and recommend standards and methodologies to the Legislative
4 Assembly for:

5 (A) Review of administrative expenses of health insurers;

6 (B) Approval of rates; and

7 (C) Enforcement of rating rules adopted by the Department of Consumer and Business
8 Services;

9 (k) Structure reimbursement rates for providers that serve recipients of medical assis-
10 tance to reward comprehensive management of diseases, quality outcomes and the efficient
11 use of resources and to promote cost-effective procedures, services and programs including,
12 without limitation, preventive health, dental and primary care services, web-based office vis-
13 its, telephone consultations and telemedicine consultations;

14 (L) Guide and support community three-share agreements in which an employer, state or
15 local government and an individual all contribute a portion of a premium for a community-
16 centered health initiative or for insurance coverage;

17 (m) Develop, in consultation with the Department of Consumer and Business Services,
18 one or more products designed to provide more affordable options for the small group mar-
19 ket;

20 (n) Implement policies and programs to expand the skilled, diverse workforce as de-
21 scribed in ORS 414.018 (4); and

22 (o) Implement a process for collecting the health outcome and quality measure data
23 identified by the [*Health Plan Quality Metrics Committee and*] **Metrics and Scoring Com-**
24 **mittee**, the Behavioral Health Committee **and the authority** and report the data to the Ore-
25 gon Health Policy Board.

26 (2) The Oregon Health Authority is authorized to:

27 (a) Create an all-claims, all-payer database to collect health care data and monitor and
28 evaluate health care reform in Oregon and to provide comparative cost and quality informa-
29 tion to consumers, providers and purchasers of health care about Oregon's health care sys-
30 tems and health plan networks in order to provide comparative information to consumers.

31 (b) Develop uniform contracting standards for the purchase of health care, including the

1 following:

2 (A) Uniform quality standards and performance measures;

3 (B) Evidence-based guidelines for major chronic disease management and health care
4 services with unexplained variations in frequency or cost;

5 (C) Evidence-based effectiveness guidelines for select new technologies and medical
6 equipment;

7 (D) A statewide drug formulary that may be used by publicly funded health benefit
8 plans; and

9 (E) Standards that accept and consider tribal-based practices for mental health and sub-
10 stance abuse prevention, counseling and treatment for persons who are Native American or
11 Alaska Native as equivalent to evidence-based practices.

12 (3) The enumeration of duties, functions and powers in this section is not intended to be
13 exclusive nor to limit the duties, functions and powers imposed on or vested in the Oregon
14 Health Authority by ORS 413.006 to 413.042, 415.012 to 415.430, 415.501, 741.001 to
15 741.540, 741.802 and 741.900 or by other statutes.

16 **SECTION 8.** ORS 414.025, as amended by section 31, chapter 26, Oregon Laws 2026,
17 and section 35, chapter 44, Oregon Laws 2026, is amended to read:

18 414.025. As used in this chapter and ORS chapters 411 and 413, unless the context or a
19 specially applicable statutory definition requires otherwise:

20 (1)(a) “Alternative payment methodology” means a payment other than a fee-for-services
21 payment, used by coordinated care organizations as compensation for the provision of inte-
22 grated and coordinated health care and services.

23 (b) “Alternative payment methodology” includes, but is not limited to:

24 (A) Shared savings arrangements;

25 (B) Bundled payments; and

26 (C) Payments based on episodes.

27 (2) “Behavioral health assessment” means an evaluation by a behavioral health clinician,
28 in person or using telemedicine, to determine a patient’s need for immediate crisis stabiliza-
29 tion.

30 (3) “Behavioral health clinician” means:

31 (a) A licensed psychiatrist;

1 (b) A licensed psychologist;

2 (c) A licensed nurse practitioner with a specialty in psychiatric mental health;

3 (d) A licensed clinical social worker;

4 (e) A licensed professional counselor or licensed marriage and family therapist;

5 (f) A licensed behavioral health and wellness practitioner;

6 (g) An intern, associate or resident who is working under a board-approved supervisory
7 contract in a clinical mental health field; or

8 (h) Any other clinician who is credentialed by the state and whose authorized scope of
9 practice includes mental health diagnosis and treatment.

10 (4) “Behavioral health crisis” means a disruption in an individual’s mental or emotional
11 stability or functioning resulting in an urgent need for immediate outpatient treatment in an
12 emergency department or admission to a hospital to prevent a serious deterioration in the in-
13 dividual’s mental or physical health.

14 (5) “Behavioral health home” means a mental health disorder or substance use disorder
15 treatment organization, as defined by the Oregon Health Authority by rule, that provides in-
16 tegrated health care to individuals whose primary diagnoses are mental health disorders or
17 substance use disorders.

18 (6) “Category of aid” means assistance provided by the Oregon Supplemental Income
19 Program, aid granted under ORS 411.877 to 411.896 and 412.001 to 412.069 or federal Sup-
20 plemental Security Income payments.

21 (7) “Community health worker” means an individual who meets qualification criteria
22 adopted by the authority under ORS 414.665 and who:

23 (a) Has expertise or experience in public health;

24 (b) Works in an urban or rural community, either for pay or as a volunteer in association
25 with a local health care system;

26 (c) To the extent practicable, shares ethnicity, language, socioeconomic status and life ex-
27 periences with the residents of the community the worker serves;

28 (d) Assists members of the community to improve their health and increases the capacity
29 of the community to meet the health care needs of its residents and achieve wellness;

30 (e) Provides health education and information that is culturally appropriate to the indi-
31 viduals being served;

- (f) Assists community residents in receiving the care they need;
- (g) May give peer counseling and guidance on health behaviors; and
- (h) May provide direct services such as first aid or blood pressure screening.

(8) “Coordinated care organization” means an organization meeting criteria adopted by the [*Oregon Health Authority*] **authority** under ORS 414.572.

(9) “Dental subcontractor” means a prepaid managed care health services organization that enters into a noncomprehensive risk contract with a coordinated care organization or the [*Oregon Health Authority*] **authority** to provide dental services to medical assistance recipients.

(10) “Doula” means a trained professional who provides continuous physical, emotional and informational support to an individual during pregnancy, labor and delivery or the postpartum period to help the individual achieve the healthiest and most satisfying experience possible.

(11) “Dually eligible for Medicare and Medicaid” means, with respect to eligibility for enrollment in a coordinated care organization, that an individual is eligible for health services funded by Title XIX of the Social Security Act and is:

- (a) Eligible for or enrolled in Part A of Title XVIII of the Social Security Act; or
- (b) Enrolled in Part B of Title XVIII of the Social Security Act.

(12)(a) “Family support specialist” means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides supportive services to and has experience parenting a child who:

- (A) Is a current or former consumer of mental health or addiction treatment; or
- (B) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

(b) A “family support specialist” may be a peer wellness specialist or a peer support specialist.

(13) “Global budget” means a total amount established prospectively by the [*Oregon Health Authority*] **authority** to be paid to a coordinated care organization for the delivery of, management of, access to and quality of the health care delivered to members of the coordinated care organization.

(14) “Health insurance exchange” or “exchange” means an American Health Benefit

1 Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

2 (15) “Health services” means at least so much of each of the following as are funded by
3 the Legislative Assembly based upon the prioritized list of health services compiled by the
4 Health Evidence Review Commission under ORS 414.690:

5 (a) Services required by federal law to be included in the state’s medical assistance pro-
6 gram in order for the program to qualify for federal funds;

7 (b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner li-
8 censed under ORS 678.375, a behavioral health clinician or other licensed practitioner
9 within the scope of the practitioner’s practice as defined by state law, and ambulance ser-
10 vices;

11 (c) Prescription drugs;

12 (d) Laboratory and X-ray services;

13 (e) Medical equipment and supplies;

14 (f) Mental health services;

15 (g) Chemical dependency services;

16 (h) Emergency dental services;

17 (i) Nonemergency dental services;

18 (j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m)
19 of this subsection, defined by federal law that may be included in the state’s medical assis-
20 tance program;

21 (k) Emergency hospital services;

22 (L) Outpatient hospital services; and

23 (m) Inpatient hospital services.

24 (16) “Income” has the meaning given that term in ORS 411.704.

25 (17)(a) “Integrated health care” means care provided to individuals and their families in
26 a patient centered primary care home or behavioral health home by licensed primary care
27 clinicians, behavioral health clinicians and other care team members, working together to
28 address one or more of the following:

29 (A) Mental illness.

30 (B) Substance use disorders.

31 (C) Health behaviors that contribute to chronic illness.

(D) Life stressors and crises.

(E) Developmental risks and conditions.

(F) Stress-related physical symptoms.

(G) Preventive care.

(H) Ineffective patterns of health care utilization.

(b) As used in this subsection, “other care team members” includes but is not limited to:

(A) Qualified mental health professionals or qualified mental health associates meeting requirements adopted by the [*Oregon Health Authority*] **authority** by rule;

(B) Peer wellness specialists;

(C) Peer support specialists;

(D) Community health workers who have completed a state-certified training program;

(E) Personal health navigators; or

(F) Other qualified individuals approved by the [*Oregon Health Authority*] **authority**.

(18) “Investments and savings” means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the department or the authority may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

(19) “Medical assistance” means so much of the medical, mental health, preventive, supportive, palliative and remedial care and services as may be prescribed by the authority according to the standards established pursuant to ORS 414.065, including premium assistance under ORS 414.115 and 414.117, payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of health services and for services described in ORS 414.710.

(20) “Medical assistance” includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. Except as provided in ORS 411.439 and 411.447, “medical assistance” does not include care or services for a resident of a nonmedical public institution.

(21) “Mental health drug” means a type of legend drug, as defined in ORS 414.325, specified by the [*Oregon Health Authority*] **authority** by rule, including but not limited to:

(a) Therapeutic class 7 ataractics-tranquilizers; and

(b) Therapeutic class 11 psychostimulants-antidepressants.

(22) “Patient centered primary care home” means a health care team or clinic that is organized in accordance with the standards established by the [*Oregon Health Authority*] **authority** under ORS 414.655 and that incorporates the following core attributes:

(a) Access to care;

(b) Accountability to consumers and to the community;

(c) Comprehensive whole person care;

(d) Continuity of care;

(e) Coordination and integration of care; and

(f) Person and family centered care.

(23) “Peer support specialist” means any of the following individuals who meet qualification criteria adopted by the authority under ORS 414.665 and who provide supportive services to a current or former consumer of mental health or addiction treatment:

(a) An individual who is a current or former consumer of mental health treatment; or

(b) An individual who is in recovery, as defined by the [*Oregon Health Authority*] **authority** by rule, from an addiction disorder.

(24) “Peer wellness specialist” means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who is responsible for assessing mental health and substance use disorder service and support needs of a member of a coordinated care organization through community outreach, assisting members with access to available services and resources, addressing barriers to services and providing education and information about available resources for individuals with mental health or substance use disorders in order to reduce stigma and discrimination toward consumers of mental health and substance use disorder services and to assist the member in creating and maintaining recovery, health and wellness.

(25) “Person centered care” means care that:

(a) Reflects the individual patient’s strengths and preferences;

(b) Reflects the clinical needs of the patient as identified through an individualized assessment; and

(c) Is based upon the patient’s goals and will assist the patient in achieving the goals.

(26) “Personal health navigator” means an individual who meets qualification criteria

adopted by the authority under ORS 414.665 and who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

(27) "Prepaid managed care health services organization" means a managed dental care, mental health or chemical dependency organization that contracts with the authority under ORS 414.654 or with a coordinated care organization on a prepaid capitated basis to provide health services to medical assistance recipients.

(28) "Quality measure" means the health outcome and quality measures and benchmarks identified by the [*Health Plan Quality Metrics Committee and the metrics and scoring subcommittee in accordance with ORS 413.017 (4) and 413.022*] **authority, the Metrics and Scoring Committee in accordance with ORS 413.022** and the quality metrics developed by the Behavioral Health Committee in accordance with ORS 413.017 [(5)] **(4)**.

(29)(a) "Quality of life in general measure" means an assessment of the value, effectiveness or cost-effectiveness of a treatment that gives greater value to a year of life lived in perfect health than the value given to a year of life lived in less than perfect health.

(b) "Quality of life in general measure" does not mean an assessment of the value, effectiveness or cost-effectiveness of a treatment during a clinical trial in which a study participant is asked to rate the participant's physical function, pain, general health, vitality, social functions or other similar domains.

(30) "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

(31) "Social determinants of health" means:

(a) Nonmedical factors that influence health outcomes;

(b) The conditions in which individuals are born, grow, work, live and age; and

(c) The forces and systems that shape the conditions of daily life, such as economic policies and systems, development agendas, social norms, social policies, racism, climate change and political systems.

(32) "Tribal traditional health worker" means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who:

(a) Has expertise or experience in public health;

(b) Works in a tribal community or an urban Indian community, either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community the worker serves;

(d) Assists members of the community to improve their health, including physical, behavioral and oral health, and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community residents in receiving the care they need;

(g) May give peer counseling and guidance on health behaviors; and

(h) May provide direct services, such as tribal-based practices.

(33)(a) “Youth support specialist” means an individual who meets qualification criteria adopted by the authority under ORS 414.665 and who, based on a similar life experience, provides supportive services to an individual who:

(A) Is not older than 30 years of age; and

(B)(i) Is a current or former consumer of mental health or addiction treatment; or

(ii) Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barrier.

(b) A “youth support specialist” may be a peer wellness specialist or a peer support specialist.

SECTION 9. ORS 417.721 is amended to read:

417.721. The Oregon Health Authority, the [*Health Plan Quality Metrics Committee*] **Metrics and Scoring Committee** and the Early Learning Council shall work collaboratively with coordinated care organizations to develop performance metrics for prenatal care, delivery and infant care that align with early learning outcomes.

SECTION 10. ORS 243.135 is amended to read:

243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the Public Employees’ Benefit Board, the board shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees, the state

1 and the local governments. In considering whether to enter into a contract for a plan, the
2 board shall place emphasis on:

3 (a) Employee choice among high quality plans;

4 (b) A competitive marketplace;

5 (c) Plan performance and information;

6 (d) Employer flexibility in plan design and contracting;

7 (e) Quality customer service;

8 (f) Creativity and innovation;

9 (g) Plan benefits as part of total employee compensation;

10 (h) The improvement of employee health; and

11 (i) Health outcome and quality measures[, *described in ORS 413.017 (4)*,] that are re-
12 ported by the plan.

13 (2) The board may approve more than one carrier for each type of plan contracted for
14 and offered but the number of carriers shall be held to a number consistent with adequate
15 service to eligible employees and their family members.

16 (3) Where appropriate for a contracted and offered health benefit plan, the board shall
17 provide options under which an eligible employee may arrange coverage for family mem-
18 bers. The board shall impose a surcharge in an amount determined by the board on an eligi-
19 ble employee who arranges coverage for the employee's spouse or dependent under this
20 subsection if the spouse or dependent has access to medical coverage as an employee in an-
21 other health benefit plan offered by the board or the Oregon Educators Benefit Board.

22 (4) Payroll deductions for costs that are not payable by the state or a local government
23 may be made upon receipt of a signed authorization from the employee indicating an elec-
24 tion to participate in the plan or plans selected and the deduction of a certain sum from the
25 employee's pay.

26 (5) In developing any health benefit plan, the board may provide an option of additional
27 coverage for eligible employees and their family members at an additional cost or premium.

28 (6) Transfer of enrollment from one plan to another shall be open to all eligible employ-
29 ees and their family members under rules adopted by the board. Because of the special prob-
30 lems that may arise in individual instances under comprehensive group practice plan
31 coverage involving acceptable provider-patient relations between a particular panel of

1 providers and particular eligible employees and their family members, the board shall pro-
2 vide a procedure under which any eligible employee may apply at any time to substitute a
3 health service benefit plan for participation in a comprehensive group practice benefit plan.

4 (7) The board shall evaluate a benefit plan that serves a limited geographic region of this
5 state according to the criteria described in subsection (1) of this section.

6 (8)(a) The board shall use payment methodologies in self-insured health benefit plans of-
7 fered by the board that are designed to limit the growth in per-member expenditures for
8 health services to no more than 3.4 percent per year. The assessment paid in accordance with
9 section 3, chapter 538, Oregon Laws 2017, shall be excluded in determining the 3.4 percent
10 annual increase in per-member expenditures for health services.

11 (b) The board shall adopt policies and practices designed to limit the annual increase in
12 premium amounts paid for contracted health benefit plans to 3.4 percent.

13 (9) As frequently as is recommended as a commercial best practice by consultants en-
14 gaged by the board, the board shall conduct an audit of the health benefit plan enrollees'
15 continued eligibility for coverage as spouses or dependents or any other basis that would af-
16 fect the cost of the premium for the plan.

17 (10) If the board spends less than 12 percent of its total medical expenditures in self-
18 insured health benefit plans on payments for primary care, the board shall implement a
19 plan for increasing the percentage of total medical expenditures spent on payments for pri-
20 mary care by at least one percent each year.

21 (11) No later than February 1 of each year, the board shall report to the Legislative As-
22 sembly on any plan implemented under subsection (10) of this section and on the board's
23 progress toward achieving the target of spending at least 12 percent of total medical expen-
24 ditures in self-insured health benefit plans on payments for primary care.

25 **SECTION 11.** ORS 243.135, as amended by section 19, chapter 4, Oregon Laws 2025, is
26 amended to read:

27 243.135. (1) Notwithstanding any other benefit plan contracted for and offered by the
28 Public Employees' Benefit Board, the board shall contract for a health benefit plan or plans
29 best designed to meet the needs and provide for the welfare of eligible employees, the state
30 and the local governments. In considering whether to enter into a contract for a plan, the
31 board shall place emphasis on:

- 1 (a) Employee choice among high quality plans;
- 2 (b) A competitive marketplace;
- 3 (c) Plan performance and information;
- 4 (d) Employer flexibility in plan design and contracting;
- 5 (e) Quality customer service;
- 6 (f) Creativity and innovation;
- 7 (g) Plan benefits as part of total employee compensation;
- 8 (h) The improvement of employee health; and
- 9 (i) Health outcome and quality measures[, *described in ORS 413.017 (4)*,] that are re-
- 10 ported by the plan.

11 (2) The board may approve more than one carrier for each type of plan contracted for
 12 and offered but the number of carriers shall be held to a number consistent with adequate
 13 service to eligible employees and their family members.

14 (3) Where appropriate for a contracted and offered health benefit plan, the board shall
 15 provide options under which an eligible employee may arrange coverage for family mem-
 16 bers. The board shall impose a surcharge in an amount determined by the board on an eligi-
 17 ble employee who arranges coverage for the employee's spouse or dependent under this
 18 subsection if the spouse or dependent has access to medical coverage as an employee in an-
 19 other health benefit plan offered by the board or the Oregon Educators Benefit Board.

20 (4) Payroll deductions for costs that are not payable by the state or a local government
 21 may be made upon receipt of a signed authorization from the employee indicating an elec-
 22 tion to participate in the plan or plans selected and the deduction of a certain sum from the
 23 employee's pay.

24 (5) In developing any health benefit plan, the board may provide an option of additional
 25 coverage for eligible employees and their family members at an additional cost or premium.

26 (6) Transfer of enrollment from one plan to another shall be open to all eligible employ-
 27 ees and their family members under rules adopted by the board. Because of the special prob-
 28 lems that may arise in individual instances under comprehensive group practice plan
 29 coverage involving acceptable provider-patient relations between a particular panel of
 30 providers and particular eligible employees and their family members, the board shall pro-
 31 vide a procedure under which any eligible employee may apply at any time to substitute a

1 health service benefit plan for participation in a comprehensive group practice benefit plan.

2 (7) The board shall evaluate a benefit plan that serves a limited geographic region of this
3 state according to the criteria described in subsection (1) of this section.

4 (8)(a) The board shall use payment methodologies in self-insured health benefit plans of-
5 fered by the board that are designed to limit the growth in per-member expenditures for
6 health services to no more than 3.4 percent per year.

7 (b) The board shall adopt policies and practices designed to limit the annual increase in
8 premium amounts paid for contracted health benefit plans to 3.4 percent.

9 (9) As frequently as is recommended as a commercial best practice by consultants en-
10 gaged by the board, the board shall conduct an audit of the health benefit plan enrollees'
11 continued eligibility for coverage as spouses or dependents or any other basis that would af-
12 fect the cost of the premium for the plan.

13 (10) If the board spends less than 12 percent of its total medical expenditures in self-
14 insured health benefit plans on payments for primary care, the board shall implement a
15 plan for increasing the percentage of total medical expenditures spent on payments for pri-
16 mary care by at least one percent each year.

17 (11) No later than February 1 of each year, the board shall report to the Legislative As-
18 sembly on any plan implemented under subsection (10) of this section and on the board's
19 progress toward achieving the target of spending at least 12 percent of total medical expen-
20 ditures in self-insured health benefit plans on payments for primary care.

21 **SECTION 12.** ORS 243.866 is amended to read:

22 243.866. (1) The Oregon Educators Benefit Board shall contract for benefit plans best de-
23 signed to meet the needs and provide for the welfare of eligible employees, the districts and
24 local governments. In considering whether to enter into a contract for a benefit plan, the
25 board shall place emphasis on:

- 26 (a) Employee choice among high-quality plans;
- 27 (b) Encouragement of a competitive marketplace;
- 28 (c) Plan performance and information;
- 29 (d) District and local government flexibility in plan design and contracting;
- 30 (e) Quality customer service;
- 31 (f) Creativity and innovation;

1 (g) Plan benefits as part of total employee compensation;

2 (h) Improvement of employee health; and

3 (i) Health outcome and quality measures[, *described in ORS 413.017 (4)*,] that are re-
4 ported by the plan.

5 (2) The board may approve more than one carrier for each type of benefit plan offered,
6 but the board shall limit the number of carriers to a number consistent with adequate service
7 to eligible employees and family members. The board shall impose a surcharge in an
8 amount determined by the board on an eligible employee who arranges coverage for the em-
9 ployee's spouse or dependent under this subsection if the spouse or dependent has access to
10 medical coverage as an employee in another health benefit plan offered by the board or the
11 Public Employees' Benefit Board.

12 (3) When appropriate, the board shall provide options under which an eligible employee
13 may arrange coverage for family members under a benefit plan.

14 (4) A district or a local government shall provide that payroll deductions for benefit plan
15 costs that are not payable by the district or local government may be made upon receipt of a
16 signed authorization from the employee indicating an election to participate in the benefit
17 plan or plans selected and allowing the deduction of those costs from the employee's pay.

18 (5) In developing any benefit plan, the board may provide an option of additional cover-
19 age for eligible employees and family members at an additional premium.

20 (6) The board shall adopt rules providing that transfer of enrollment from one benefit
21 plan to another is open to all eligible employees and family members. Because of the special
22 problems that may arise involving acceptable provider-patient relations between a particular
23 panel of providers and a particular eligible employee or family member under a compre-
24 hensive group practice benefit plan, the board shall provide a procedure under which any el-
25 igible employee may apply at any time to substitute another benefit plan for participation in
26 a comprehensive group practice benefit plan.

27 (7) An eligible employee who is retired is not required to participate in a health benefit
28 plan offered under this section in order to obtain dental benefit plan coverage. The board
29 shall establish by rule standards of eligibility for retired employees to participate in a dental
30 benefit plan.

31 (8) The board shall evaluate a benefit plan that serves a limited geographic region of this

1 state according to the criteria described in subsection (1) of this section.

2 (9)(a) The board shall use payment methodologies in self-insured health benefit plans of-
3 ferred by the board that are designed to limit the growth in per-member expenditures for
4 health services to no more than 3.4 percent per year.

5 (b) The board shall adopt policies and practices designed to limit the annual increase in
6 premium amounts paid for contracted health benefit plans to 3.4 percent.

7 (10) As frequently as is recommended as a commercial best practice by consultants en-
8 gaged by the board, the board shall conduct an audit of the health benefit plan enrollees'
9 continued eligibility for coverage as spouses or dependents or any other basis that would af-
10 fect the cost of the premium for the plan.

11 (11) If the board spends less than 12 percent of its total medical expenditures in self-
12 insured health benefit plans on payments for primary care, the board shall implement a
13 plan for increasing the percentage of total medical expenditures spent on payments for pri-
14 mary care by at least one percent each year.

15 (12) No later than February 1 of each year, the board shall report to the Legislative As-
16 sembly on any plan implemented under subsection (11) of this section and on the board's
17 progress toward achieving the target of spending at least 12 percent of total medical expen-
18 ditures on payments for primary care.

19 **SECTION 13.** Section 15, chapter 584, Oregon Laws 2023, is amended to read:

20 **Sec. 15.** *[(1) Notwithstanding ORS 414.638 (3), the downstream health outcome and*
21 *quality measures for reporting year 2024 shall be selected by the metrics and scoring sub-*
22 *committee from the Health Plan Quality Metrics Committee's Aligned Measure Menu Set*
23 *adopted by the Health Plan Quality Metrics Committee as of the effective date of this 2023*
24 *Act.]*

25 *[(2)]* Notwithstanding ORS *[414.638 (3)]* **413.022 (3)**, until September 30, 2027, the *[met-*
26 *rics and scoring subcommittee]* **Metrics and Scoring Committee** may prioritize the fol-
27 lowing upstream health outcome and quality measures, at a minimum:

28 *[(a)]* **(1)** Health assessments for children in the custody of the Department of Human
29 Services.

30 *[(b)]* **(2)** Addressing the social and emotional health of young children to ensure the chil-
31 dren are prepared for kindergarten.

1 [(c)] (3) Meaningful language access to culturally responsive health care services.

2 [(d)] (4) Screening for social needs and referrals to address the social determinants of
3 health.

4 **SECTION 14.** Section 2, chapter 575, Oregon Laws 2015, as amended by section 1, chap-
5 ter 384, Oregon Laws 2017, section 13, chapter 489, Oregon Laws 2017, and section 171,
6 chapter 73, Oregon Laws 2024, is amended to read:

7 **Sec. 2.** (1) As used in this section:

8 (a) “Carrier” means an insurer that offers a health benefit plan, as defined in ORS
9 743B.005.

10 (b) “Coordinated care organization” has the meaning given that term in ORS 414.025.

11 (c) “Primary care” means family medicine, general internal medicine, naturopathic
12 medicine, obstetrics and gynecology, pediatrics or general psychiatry.

13 (d) “Primary care provider” includes:

14 (A) A physician, naturopath, nurse practitioner, physician associate or other health pro-
15 fessional licensed or certified in this state, whose clinical practice is in the area of primary
16 care.

17 (B) A health care team or clinic that has been certified by the Oregon Health Authority as
18 a patient centered primary care home.

19 (2)(a) The Oregon Health Authority shall convene a primary care payment reform col-
20 laborative to advise and assist in the implementation of a Primary Care Transformation Ini-
21 tiative to:

22 (A) Use value-based payment methods that are not paid on a per claim basis to:

23 (i) Increase the investment in primary care;

24 (ii) Align primary care reimbursement by all purchasers of care; and

25 (iii) Continue to improve reimbursement methods, including by investing in the social
26 determinants of health;

27 (B) Increase investment in primary care without increasing costs to consumers or increas-
28 ing the total cost of health care;

29 (C) Provide technical assistance to clinics and payers in implementing the initiative;

30 (D) Aggregate the data from and align the metrics used in the initiative with the work of
31 the [*Health Plan Quality Metrics Committee established in ORS 413.017*] **Metrics and**

Scoring Committee established in ORS 413.022;

(E) Facilitate the integration of primary care behavioral and physical health care; and

(F) Ensure that the goals of the initiative are met by December 31, 2027.

(b) The collaborative is a governing body, as defined in ORS 192.610.

(3) The authority shall invite representatives from all of the following to participate in the primary care payment reform collaborative:

(a) Primary care providers;

(b) Health care consumers;

(c) Experts in primary care contracting and reimbursement;

(d) Independent practice associations;

(e) Behavioral health treatment providers;

(f) Third party administrators;

(g) Employers that offer self-insured health benefit plans;

(h) The Department of Consumer and Business Services;

(i) Carriers;

(j) A statewide organization for mental health professionals who provide primary care;

(k) A statewide organization representing federally qualified health centers;

(L) A statewide organization representing hospitals and health systems;

(m) A statewide professional association for family physicians;

(n) A statewide professional association for physicians;

(o) A statewide professional association for nurses; and

(p) The Centers for Medicare and Medicaid Services.

(4) The primary care payment reform collaborative shall annually report to the Oregon Health Policy Board and to the Legislative Assembly on the achievement of the primary care spending targets in ORS 414.572 and 743.010 and the implementation of the Primary Care Transformation Initiative.

(5) A coordinated care organization shall report to the authority, no later than October 1 of each year, the proportion of the organization's total medical costs that are allocated to primary care.

(6) The authority, in collaboration with the Department of Consumer and Business Services, shall adopt rules prescribing the primary care services for which costs must be reported

under subsection (5) of this section.

HEALTH CARE PROVIDER INCENTIVE FUND

SECTION 15. ORS 676.467 is amended to read:

676.467. (1) On the basis of the assessment and the evaluation conducted under ORS 676.459 and 676.463, the Oregon Health [*Policy Board*] **Authority** shall determine the best allocation of moneys in the Health Care Provider Incentive Fund established under ORS 676.450 toward providing:

(a) Incentives through the health care provider incentive program created by ORS 676.454.

(b) Loans or grants to support communities' plans for addressing the unmet health care workforce needs in each community, including but not limited to:

(A) Funding start-up costs for new health care professional training programs that:

(i) Are designed to expand the racial and ethnic diversity of Oregon's health care workforce;

(ii) Are designed to expand the health care workforce in medically underserved areas;

(iii) Provide financial incentives to faculty members in health care professional training programs and clinical preceptors;

(iv) Ensure that individuals enrolled in the programs are adequately compensated; and

(v) Include technical assistance; and

(B) Supplementing Medicare funding paid to hospitals for graduate medical education.

(2) With respect to the loans and grants provided under subsection (1)(b) of this section, the [*board*] **authority** shall:

(a) Prescribe the process and procedures for communities to apply for loans or grants and for the [*board*] **authority** to award loans and grants.

(b) Establish criteria to ensure that the moneys support community plans that:

(A) Include a substantial financial investment by the community, as determined by the [*board*] **authority**, and may include financial or in-kind support;

(B) Are designed to improve the access to health care by medical assistance recipients and Medicare enrollees to the same extent that each plan improves access to health care by

1 the general population of the community; and

2 (C) Are sustainable over the long term.

3 (c) Conduct outreach to communities to solicit ideas and applications for new training
4 programs and other incentive programs.

5 (d) Collaborate with community colleges and public universities in this state.

6 (3) The [*board*] **authority** shall enter into an agreement with the Oregon Health and Sci-
7 ence University to administer this section under the [*board's*] **authority's** direction.

8 **(4) The authority shall submit a biennial report to the Oregon Health Policy**
9 **Board regarding the allocation of moneys in the Health Care Provider Incentive**
10 **Fund.**

11 12 **HEALTH INSURANCE EXCHANGE ADVISORY COMMITTEE**

13
14 **SECTION 16.** ORS 741.004 is amended to read:

15 741.004. (1) The Health Insurance Exchange Advisory Committee is created to advise the
16 Oregon Health Policy Board in the development and implementation of the policies and op-
17 erational procedures governing the administration of a health insurance exchange in this
18 state including, but not limited to, all of the following:

19 (a) The amount of the assessment imposed on insurers under ORS 741.105.

20 (b) The operation of a Small Business Health Options Program in accordance with 42
21 U.S.C. 18031.

22 (c) The processes and procedures to enable each insurance producer to be authorized to
23 act for all of the insurers offering qualified health plans through the health insurance ex-
24 change.

25 (d) The affordability of qualified health plans offered by employers under section
26 5000A(e)(1) of the Internal Revenue Code.

27 (e) Outreach strategies for reaching minority and low-income communities.

28 (f) Solicitation of customer feedback.

29 (g) The affordability of health plans offered through the exchange.

30 (2) The committee consists of [*15*] **13** members. [*Thirteen*] **Eleven** members shall be ap-
31 pointed by the Governor and are subject to confirmation by the Senate in the manner

prescribed in ORS 171.562 and 171.565. The appointed members serve at the pleasure of the Governor. The Director of the Oregon Health Authority or the director's designee and the Director of the Department of Consumer and Business Services or the director's designee shall serve as ex officio members of the committee.

(3) The [13] **11** members appointed by the Governor must represent the interests of:

(a) Insurers;

(b) Insurance producers;

(c) Navigators, in-person assisters, application counselors and other individuals with experience in facilitating enrollment in qualified health plans, **including facilitating enrollment for hard-to-reach populations;**

(d) Health care providers;

(e) The business community, including small businesses and self-employed individuals; **and**

[(f) Consumer advocacy groups, including advocates for enrolling hard-to-reach populations;]

[(g)](f) Enrollees in qualified health plans[; and].

[(h) State agencies that administer the medical assistance program under ORS chapter 414.]

(4) The Oregon Health Policy Board or the Director of the Oregon Health Authority may solicit recommendations from the committee and the committee may initiate recommendations on its own.

(5) The committee may provide annual reports to the Legislative Assembly, in the manner provided in ORS 192.245, of the findings and recommendations the committee considers appropriate, including but not limited to a report on the:

(a) Adequacy of assessments for reserve programs and administrative costs;

(b) Operation of the Small Business Health Options Program;

(c) Number of qualified health plans offered through the exchange;

(d) Number and demographics of individuals enrolled in qualified health plans;

(e) Advance premium tax credits provided to enrollees in qualified health plans; and

(f) Feedback from the community about satisfaction with the operation of the exchange and qualified health plans offered through the exchange.

(6) The members of the committee shall be appointed for a term fixed by the Governor, not to exceed two years, and shall serve without compensation, but shall be entitled to travel expenses in accordance with ORS 292.495. The committee may hire, subject to the approval of the director, such experts as the committee may require to discharge its duties. All expenses of the committee shall be paid out of the Health Insurance Exchange Fund established in ORS 741.102.

(7) The employees of the Oregon Health Authority responsible for administering the health insurance exchange are directed to assist the committee in the performance of its duties under subsection (1) of this section and, to the extent permitted by laws relating to confidentiality, to furnish such information and advice as the members of the committee consider necessary to perform their duties under subsection (1) of this section.

OEGB MEMBERSHIP

SECTION 17. ORS 243.862 is amended to read:

243.862. (1) There is established in the Oregon Health Authority an Oregon Educators Benefit Board consisting of at least [10] **11** members appointed by the Governor, including:

(a) Two members representing district boards;

(b) Two members representing district management;

(c) Two members representing nonmanagement district employees from the largest labor organization representing district employees;

(d) One member representing nonmanagement district employees from the second largest labor organization representing district employees;

(e) One member representing nonmanagement district employees who are not represented by labor organizations described in paragraphs (c) and (d) of this subsection;

(f) [*One member*] **Two members** with expertise in health policy or risk management; and

(g) One member who is employed as classified staff at a public school or for an education service district.

(2)(a) If the governing body of a local government elects to participate in a benefit plan offered by the board, in addition to the members appointed under subsection (1) of this

1 section, the Governor shall appoint two members, one of whom represents local government
2 management and one of whom represents local government nonmanagement employees.

3 (b) After the appointment of members under paragraph (a) of this subsection, if the
4 number of eligible employees of a local government or local governments enrolled in a bene-
5 fit plan or plans offered by the board exceeds 25,000, the Governor shall appoint two addi-
6 tional members, one of whom represents local government management and one of whom
7 represents local government nonmanagement employees.

8 (c) After the appointment of members under paragraphs (a) and (b) of this subsection, for
9 every additional 25,000 eligible employees of a local government or local governments en-
10 rolled in a benefit plan or plans offered by the board, the Governor shall appoint one addi-
11 tional member representing local government management and one additional member
12 representing local government nonmanagement employees.

13 (3) A maximum of three members may be appointed to represent local government
14 management and a maximum of three members may be appointed to represent local gov-
15 ernment nonmanagement employees.

16 (4) The term of office of each member is four years, but a member serves at the pleasure
17 of the Governor. Before the expiration of the term of a member, the Governor shall appoint a
18 successor to take office upon the date of that expiration. A member is eligible for reappoint-
19 ment. If there is a vacancy for any cause, the Governor shall make an appointment to be-
20 come immediately effective for the unexpired term.

21 (5) A member of the board is not entitled to compensation, but may be reimbursed from
22 funds available to the board for actual and necessary travel and other expenses incurred by
23 the member in the performance of the member's official duties in the manner and amount
24 provided in ORS 292.495.

25 (6) The board shall select one of its members as chairperson and another as vice chairper-
26 son, for such terms and with duties and powers necessary for the performance of the func-
27 tions of such offices as the board determines.

28 (7) A majority of the members of the board constitutes a quorum for the transaction of
29 business.

30 (8) The board shall meet at times and places specified by the call of the chairperson or of
31 a majority of the members of the board.

(9) Appointments of members to the board by the Governor are subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565.

PEBB AND OEGB CONTRACTS

SECTION 18. ORS 279A.025 is amended to read:

279A.025. (1) Except as provided in subsections (2) to (4) of this section, the Public Contracting Code applies to all public contracting.

(2) The Public Contracting Code does not apply to:

(a) Contracts between a contracting agency and:

(A) Another contracting agency;

(B) The Oregon Health and Science University;

(C) A public university listed in ORS 352.002;

(D) The Oregon State Bar;

(E) A governmental body of another state;

(F) The federal government;

(G) A Federally Funded Research and Development Center that the National Science Foundation, or a successor agency, includes in the Master Government List of Federally Funded R&D Centers, or a similar list, however named, that the foundation or the successor agency makes publicly available;

(H) An American Indian tribe or an agency of an American Indian tribe;

(I) A nation, or a governmental body in a nation, other than the United States; or

(J) An intergovernmental entity formed between or among:

(i) Governmental bodies of this or another state;

(ii) The federal government;

(iii) An American Indian tribe or an agency of an American Indian tribe;

(iv) A nation other than the United States; or

(v) A governmental body in a nation other than the United States;

(b) Agreements authorized by ORS chapter 190 or by a statute, charter provision, ordinance or other authority for establishing agreements between or among governmental bodies or agencies or tribal governing bodies or agencies;

(c) Insurance and service contracts as provided for under ORS 414.115, 414.125, 414.135 and 414.145 for purposes of source selection;

(d) Grants;

(e) Contracts for professional or expert witnesses or consultants to provide services or testimony relating to existing or potential litigation or legal matters in which a public body is or may become interested;

(f) Acquisitions or disposals of real property or interest in real property;

(g) Sole-source expenditures when rates are set by law or ordinance for purposes of source selection;

(h) Contracts for the procurement or distribution of textbooks;

(i) Procurements by a contracting agency from an Oregon Corrections Enterprises program;

(j) The procurement, transportation, sale or distribution of distilled liquor, as defined in ORS 471.001, or the appointment of agents under ORS 471.230 or 471.750 by the Oregon Liquor and Cannabis Commission;

(k) Contracts entered into under ORS chapter 180 between the Attorney General and private counsel or special legal assistants;

(L) Contracts for the sale of timber from lands that the State Board of Forestry, the State Forestry Department, the State Parks and Recreation Commission or the State Parks and Recreation Department owns or manages;

(m) Contracts for activities necessary or convenient for the sale of timber under paragraph (L) of this subsection, either separately from or in conjunction with contracts for the sale of timber, including but not limited to activities such as timber harvesting and sorting, transporting, gravel pit development or operation, and road construction, maintenance or improvement;

(n) Contracts for forest protection or forest related activities, as described in ORS 477.406, by the State Forester or the State Board of Forestry;

(o) Contracts that the Housing and Community Services Department enters into in exercising the department's duties prescribed in ORS chapters 456 and 458, or procurements described in ORS 456.625 (19);

(p) Contracts that the State Treasurer enters into in exercising the powers of that office

prescribed in ORS 178.010 to 178.090 and 276A.242 and ORS chapters 286A, 287A, 289, 293, 294 and 295, including but not limited to investment contracts and agreements, banking services, clearing house services and collateralization agreements, bond documents, certificates of participation and other debt repayment agreements, and any associated contracts, agreements and documents, regardless of whether the obligations that the contracts, agreements or documents establish are general, special or limited, except that the State Treasurer's public contracting for goods and services is subject to ORS chapter 279B;

(q) Contracts, agreements or other documents entered into, issued or established in connection with:

(A) The issuance of obligations, as defined in ORS 286A.100 and 287A.310, of a public body;

(B) Program loans and similar extensions or advances of funds, aid or assistance that a public body makes to a public or private body for the purpose of carrying out, promoting or sustaining activities or programs authorized by law; or

(C) The investment of funds by a public body as authorized by law, and other financial transactions of a public body that by their character cannot practically be established under the competitive contractor selection procedures of ORS 279B.050 to 279B.085;

(r) Contracts for employee benefit plans as provided in ORS 243.105 (1), 243.125 (4), 243.221, 243.275, 243.291, 243.303 and 243.565, **except that ORS 279B.060 (6) applies to disclosures of such contracts before a notice of intent to award a contract is issued;**

(s) Contracts for employee benefit plans as provided in ORS 243.860 to 243.886, **except that ORS 279B.060 (6) applies to disclosures of such contracts before a notice of intent to award a contract is issued;**

(t) Any agreement that a county enters into with a real estate broker or agent, auctioneer, appraiser or any other person for the purpose of disposing of property in accordance with ORS 312.520; or

(u) Any other public contracting of a public body specifically exempted from the code by another provision of law.

(3) The Public Contracting Code does not apply to the contracting activities of:

(a) The Oregon State Lottery Commission;

(b) The legislative department;

(c) The judicial department;

(d) Semi-independent state agencies listed in ORS 182.454, except as provided in ORS 279.835 to 279.855 and 279A.250 to 279A.290;

(e) Oregon Corrections Enterprises;

(f) The Oregon Film and Video Office, except as provided in ORS 279A.100 and 279A.250 to 279A.290;

(g) The Travel Information Council, except as provided in ORS 279A.250 to 279A.290;

(h) The Oregon 529 Savings Network and the Oregon 529 Savings Board;

(i) The Oregon Innovation Council;

(j) The Oregon Utility Notification Center;

(k) The State Parks and Recreation Department, except for duties or obligations the department has under ORS 279A.250 to 279A.290 and the department's contracting activities related to information technology, as defined in ORS 276A.230, photogrammetric mapping, as defined in ORS 672.002, or telecommunications, as defined in ORS 276A.206; or

(L) Any other public body specifically exempted from the code by another provision of law.

(4) ORS 279A.200 to 279A.225 and 279B.050 to 279B.085 do not apply to contracts made with qualified nonprofit agencies providing employment opportunities for individuals with disabilities under ORS 279.835 to 279.855.

POLICE OFFICER AND FIREFIGHTER PARTICIPATION IN PEBB

SECTION 19. ORS 243.105 is amended to read:

243.105. As used in ORS 243.105 to 243.285, unless the context requires otherwise:

(1) "Benefit plan" includes, but is not limited to:

(a) Contracts for insurance or other benefits, including medical, dental, vision, life, disability and other health care recognized by state law, and related services and supplies;

(b) Comparable benefits for employees who rely on spiritual means of healing; and

(c) Self-insurance programs managed by the Public Employees' Benefit Board.

(2) "Board" means the Public Employees' Benefit Board.

(3) "Carrier" means an insurance company or health care service contractor holding a

valid certificate of authority from the Director of the Department of Consumer and Business Services, or two or more companies or contractors acting together pursuant to a joint venture, partnership or other joint means of operation, or a board-approved guarantor of benefit plan coverage and compensation.

(4)(a) “Eligible employee” means an officer or employee of a state agency or local government who elects to participate in one of the group benefit plans described in ORS 243.135. The term includes, but is not limited to, state officers and employees in the exempt, unclassified and classified service, and state officers and employees, whether or not retired, who:

(A) Are receiving a service retirement allowance, a disability retirement allowance or a pension under the Public Employees Retirement System or are receiving a service retirement allowance, a disability retirement allowance or a pension under any other retirement or disability benefit plan or system offered by the State of Oregon for its officers and employees;

(B) Are eligible to receive a service retirement allowance under the Public Employees Retirement System and have reached earliest retirement age under ORS chapter 238;

(C) Are eligible to receive a pension under ORS 238A.100 to 238A.250, and have reached earliest retirement age as described in ORS 238A.165; or

(D) Are eligible to receive a service retirement allowance or pension under another retirement benefit plan or system offered by the State of Oregon and have attained earliest retirement age under the plan or system.

(b) “Eligible employee” does not include individuals:

(A) [*Engaged*] **Who are engaged** as independent contractors;

(B) Whose periods of employment in emergency work are on an intermittent or irregular basis;

(C) Who are employed on less than half-time basis unless the individuals are employed in positions classified as job-sharing positions, unless the individuals are defined as eligible under rules of the board;

(D) [*Appointed*] **Who are appointed** under ORS 240.309, except as required by 26 U.S.C. 4980H;

(E) [*Provided*] **Who are provided** sheltered employment or make-work by the state in an employment or industries program maintained for the benefit of such individuals; **or**

(F) [*Provided*] **Who are provided** student health care services in conjunction with their enrollment as students at a public university listed in ORS 352.002[; *or*].

[(G) *Who are members of a collective bargaining unit that represents police officers or firefighters.*]

(5) “Family member” means an eligible employee’s spouse and any unmarried child or stepchild within age limits and other conditions imposed by the board with regard to unmarried children or stepchildren.

(6) “Local government” means any city, county or special district in this state or any intergovernmental entity created under ORS chapter 190.

(7) “Payroll disbursing officer” means the officer or official authorized to disburse monies in payment of salaries and wages of employees of a state agency or local government.

(8) “Premium” means the monthly or other periodic charge for a benefit plan.

(9) “Primary care” means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.

(10) “State agency” means every state officer, board, commission, department or other activity of state government.

(11) “Total medical expenditures” means payments to reimburse the cost of physical and mental health care provided to eligible employees or their family members, excluding prescription drugs, vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment mechanism.

CAPTIONS

SECTION 20. The unit captions used in this 2027 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2027 Act.